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Volume 5 Issue 1 **JUL 02**

2002 PAC Conference "The Porthole to Credentialing & Privileging"

Thank you PAC Family, and Medical/Dental Staff leaders for an exciting conference. It never ceases to amaze us how much Sandy and I learn from our PAC Family. THANK YOU all.

We were unable to answer all of the questions. Presented below are the questions remaining to be discussed.

PAC FAMILY QUESTIONS

I didn't see anything on the list of Anesthesiologist privileges showing admitting privileges. Just who has, and doesn't have admitting privileges?"

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RIGHT ON TARGET

The answer is in our Navy Medical Staff Bylaws, BUMEDINST 6010.17A, Encl (2), para 4b(1): "Only physician and dentist members of the medical staff shall be granted the privilege to independently admit to inpatient services." Therefore, specific admission privileges do not need to be granted to physicians and dentists, since admissibility to admit is located within the Bylaws.

The JCAHO revised the above standard. The Bylaws are up for signature; the following is in the *draft* 6010.17B: Enclosure 24b:

(2) DON allopathic and osteopathic physicians, oral maxillofacial surgeons, who are members of the medical staff with clinical privileges, while not specifically listed in each core privilege list, by virtue of licensure and medical staff status, are authorized to admit patients to inpatient services. Navy Medical Department facility-specific medical staff policies and procedures, enclosure (3), will delineate exceptions to the Bylaws based on facility limitations.

Therefore, all Advanced Practice Nurses (APN), and Allied Health Specialists (AHS) must be

granted supplemental delineated admission clinical privileges.

The vast majority of Navy Dental Officers do not admit patients. If the Dental Officer desires to admit a patient, and wants to follow the patient throughout the hospital stay, the Dental Officer can be granted a supplemental admission privileges. However, the same standards apply to admission privileges as to all other supplementals. The Dental Officer must have documented current competency for admission; know the hospital standards for admission; grand rounds; hospital policies, etc. If the above is not met, the Dental Officer cannot independently admit a patient.

BUMEDINST 6320.66C, Appendix G.6b, has specific admission requirements for the privileged Clinical Psychologist. Advise the Medical Staff of these requirements prior to granting a Clinical Psychologist admission privileges.

I really feel a list of "Legal" PSV websites should be put together and sent to all PACs. It is extremely difficult to decide whether a site is legal without being a lawyer, etc.

Excellent question: Websites directly accessed (no intermediary) are valid, "legal" websites, unless they show the following:

- ✓ The information is obtained directly from the professional organization's website.
- ✓ Use of a website of another recognized professional organization, such as the Administrators in Medicine (AIM) site is permitted if it is used as a platform to reach the intended site. For example: The CA Medical Board uses AIM as a platform to get to the CA Board website; this is acceptable, because the printed information comes from the CA State Board. The information is encrypted (presume it is unless otherwise stated).
- ✓ The website contains ***all*** of the information required for the PSV. For example: State license— the website should have the expired date, status (active or military exempt); standing (in good standing), and any sanctions connected to this license. If one piece of the above information is not on the website, it is an invalid website, and the PAC needs to contact the board for either a written or a telephonic PSV.
- ✓ If there are any questions, Sandy and I are available 24 hours a day via email, or voice mail.

Check the Oct 1998 DATALINK, page 4, for further information.

I save all of the emails sent to me by CDR and Sandy. I suggest a single line email address including all PACs Cred Cmte

Chairs be formulated so we don't print ¾ of a page of names. I am sure your MID Dept could develop an address book on a one line address book. I may not have received emails others have, and vice a versa.

Sandy states the following: Forward the email to yourself, then erase all the names. When you print the email the names will not print, just the body of the email.

Our Medical Staff is developing volume indicators for Departmental Specific Criteria. Please help us explain to them the development of these indicators in the DATALINK.

Excellent question; not an easy question to answer. The JCAHO, and BUMEDINST 6320.66C, Section 1, para 21.c, requires the Department Head, or equivalent, recommend Departmental Specialty Facility Specific Criteria for the Initial, Active, Active reappointment, affiliate, and temporary appointments with clinical privileges.

These criteria should address criteria for the granting of Core and supplemental privileges, which should include:

- ✓ Education/training requirements
- ✓ License requirements
- ✓ Current clinical competency requirements
- ✓ Ability to perform requirements
- ✓ Other requirements not addressed in BUMEDINST 6320.66C, Appendices E, F, G, and H. For example: If your Emergency Room (ER) desires every health care provider to obtain, and maintain, BLS and ACLS to practice in the ER, this requirement needs to be included in the ER's Departmental Specific Criteria.

Setting "Thresholds" can be difficult. A majority of professional organizations are reluctant to state how many of a certain procedure equates to current competency. Research reveals the more a procedure is performed, the higher the level of proficiency, and the lower the level of untoward outcomes. But…what is that number?

That number is for our Medical/Dental Staff leaders to decide. Is 1 delivery for a Family Practitioner within a two-year period enough to equate to current competency?

Let us look at the supplemental privilege for Medical Acupuncture. The American Academy of Medical Acupuncture (AAMA) suggests the following criteria:

- The National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), certifying board for ***non-physician*** acupuncturists, is very specific on the requirements to practice: Apprenticeship: at least 4,000 contact

hours with 500 patients per year; Professional practice – minimum 100 different patients per year, with a 500 patient per year visit record.

- The ***physician*** trained in acupuncture: 200 hours of graduate training in Medical Acupuncture, AMA Category-1; 3 letters of recommendation; minimum of 30 accredited hours over a three-year period; but, no patient visit threshold recommended. The Medical/Dental Staff would need to decide the threshold for their command.

The Core usually does not require individual thresholds for each skill listed; the Medical/Dental Staff decides if the practitioner has seen enough patients (patient volume), with the appropriate case mix (a majority of the Core), to equate to current competency for a majority of the Core. If a Core contains high-risk patients, or procedures, the Medical/Dental Staff need to make sure the practitioner has current competency in these procedures, both invasive, and non-invasive.

Supplementals should have specific thresholds. A specific threshold supports of objectivity of the granting of privileges. Privileges are granted via documented, objective, measurable criteria, and not subjective "feelings."

Our Medical/Dental Staff leaders understand their responsibility to protect the patients. We are blessed to have EXCELLENT Medical and Dental Staff leaders.

We are blessed to have EXCELLENT PAC Family members who will share their documents with you: Contact other PACs; request a copy of their Departmental Specific Criteria.

- Dental: Jack Jones, NNDC Bethesda, has excellent Dental Staff Departmental Specific Criteria. His Dental Staff leaders worked hard on developing these criteria.
- For the Medical Staff, Jo Ann, NMC Portsmouth PAC; and, Asomuamua, NMCL Pearl Harbor have excellent criteria; their Medical Staffs worked hard to develop these criteria.

Case studies: If time is always an issue, limit number of them or give better choices of outcomes to limit questions and discussion.

Excellent suggestion

We will limit the number.

The focus of the Case Studies is not the answer. Each case represents an opportunity to consider how the group would advise the Commanding Officer. The Case Studies should elicit questions, not limit, and elicit active discussion. Many of these cases have more than one-way of reaching a decision, and all the avenues to the decision making process must be explored.

Can we receive an Army or Air Force provider simply by doing the ICTB, and Appendix Q?

The ICTB is used by all three Services; therefore, you will accept the ICTB from the Army or Air Force.

The Appendix Q is another issue. It is not recognized, or used, by the Army or Air Force.

The Appendix Q is a Navy vehicle to allow the practitioner to "exercise" clinical privileges granted at the sending command.

The practitioner is requesting permission to exercise "my core privileges" at the gaining command. The Army or Air Force does not have Core privileges.

I noted the Air Force is integrating the verbiage "Core" in connection with some of their specialty privileges, and the PAC will see Core on some of the privilege pages.

Each skill has "Categories" connected with the provider's ability to perform the skill. We do not recognize this in the Navy. Yet…the practitioner still has to request each one skill individually, each category individually. The command has to grant each one individually, and attach a category to the skill.

This is not Core per the Navy definition; therefore, it would be difficult to use the Appendix Q for the Air Force or Army practitioner.

So…the question remains: Can a command use the Appendix Q with Army and Air Force practitioners. The use of the Appendix Q process for Army, Air Force practitioners, is not addressed in policy. BUMEDINST 6320.66C does not specifically mention the other Services. The focus is patient safety, and the ability of the practitioner to provide safe patient care with the privileges granted.

Therefore, the decision to use the Appendix Q for a TAD Army or Air Force practitioner is the Medical/Dental Staff's decision. It is recommended the Army/Air Force privileges be thoroughly reviewed by the Medical/Dental Staff, and the privileges are equivalent to the Core. If there are any facility restrictions (limitation) these need to be documented, and discussed with the Army/Air Force practitioner.

Are we required to verify Malpractice Insurance on a practitioner being granted Temporary Privileges?

I take it this question is referring to our contracted individuals?

Temporary privileges are only granted to:

- Fulfill an important patient care need
- When an applicant with a ***complete,*** clean application is awaiting review and approval of the ECOMS/ECODS, and privileging authority.

Temporary privileges should not be granted when a contracting agency hires someone on Thursday, and schedules this individual for work that Saturday. Not appropriate to

use Temporary Privileges in this case, unless the contracting agency submits a clean, ***complete*** application package without any "Red-Flags," and the application has been approved by the Department Head, Directorate, and Credentials Committee, if appropriate. The contracting agency rarely submits a complete, clean, package; therefore, it would not be appropriate to use Temporary Privileges in this scenario.

When to use Temporary Privileges?

- To fulfill an important patient care need.
- A situation where a specialty physician (only one in the command) becomes ill, or goes emergency TAD: Example: Your command needs a practitioner to cover his/her practice, e.g., OB/GYN coverage during the TAD. Your command is unable to obtain a Reservist OB/GYN until 7 days later. Your command needs someone, now, to assume OB/GYN patient care needs until the Reservist arrives (this may be a civilian).
- A specific practitioner has the necessary skills to provide care to a patient that a practitioner currently privileged does not possess. Example: There is an advanced dental procedure needed to manage one of your dental patients. Dr. J. Doe licensed in your State as a dentist, via an MOU with the civilian dental office, volunteers to work with your command's dentists to complete the procedure. Dr. J. Doe will be providing the direct care to your dental patient. Temporary privileges are the method to use in this scenario.

Even though the policy does not require verifying the malpractice insurance, I would still verify this information, and keep a copy of the policy information.

Currently physicians and nurses must have at least one active license. Want to confirm dentists are still waived from this requirement.

Navy Dental Officers may possess, and maintain a Military Exempt dental license. The Congressional mandate applied only to physicians.

BUMED Nurse Corps followed the physician's criteria; Navy nurses may only possess an Active license as the only license; cannot practice under a Military Exempt license as the only license.

Some commands request copies of updated credentials vice a PHONCON to update ICTB's. Is this necessary?

No, this is not necessary, and may represent a waste to resources (paper, time to copy, time to fax, etc.). Requesting copies to change an ICTB is not

within the ICTB policy directive.

ASD(HA) Policy, dtd 11 Dec 1995, para 4.e, states the ICTB shall become invalid upon the expiration of the appointment (privileges) on which it is based. If credentials have expired, telephonic or message confirmation of the renewal of the credential with the facility holding the ICF/IPF will suffice, e.g., a new ICTB is not required. A record of the telephone call, or message, will be maintained in the practitioner file at the gaining facility, e.g., stapled unto the Appendix Q for the Navy.

The outgoing CO privileged the incoming CO…is this OK? Any problem with this?

No problem with this. The reason the NHSO Jacksonville is the privileging authority for Commanding Officers (CO) is, the CO cannot sign for him/herself as the privileging authority. No can do.

Therefore, if there is a long turn-over time between the leaving, and the gaining CO, the leaving CO, as privileging authority, can approve the gaining CO's privileges, as long as the gaining CO meets the Navy standard.

Where should we file the training acronyms, e.g., BLS, ACLS, PALS, in the ICF?

These "credentials" do not belong in the ICF/IPF, but in the provider/practitioner's training file. The credential can be placed in the training file after the PAC has reviewed, and placed the dates into CCQAS 2.6.

If a training acronym is required due to a Departmental Specific Requirement (remember the ER discussion?), the credential should be maintained in Section IV with the license, and national certification information.

If the command does not maintain training files, keep these credentials in the CAF, or some other type of file. Often when I am reviewing CO packages, or OST packages, I find literally pages of expired training acronym documentation. I expunge it, since it does not belong in the credentials file.

If you can't use a CV with the PPIS, how do you handle the attached sheet when a member needs to expand on a separate page?

Good for you…you are correct; a CV is not to be placed in a credentials file. The CV is not a legal document, and the information in the CV is not primary source verified (PSV).

When a practitioner needs to expand documentation, provide lined paper, and staple this to the PPIS in sequential numbers. For example: The PPIS is page J-1 to J-5. The stapled sheet would be J-6, J-7, etc., signed, and dated by the practitioner at the end of the documentation.

Section 2-15, #8 – Privilege trainees on completion of F-T Inservice Training Program. Why don't we have one for OST Trainees?

I need some assistance here. Why don't we have "one," what(?) for OST trainees. We do privilege full-time OST trainees at the completion of the training if the graduate possesses an Active license, and current competency is documented on the PAR.

If the question is different, please call Sandy or I (904) 542-7200 X 8142/8111, and discuss issue with us.

Can we be told when a practitioner retires and their ICF is forwarded and received by Ms. Tindell (Archivist), so we may destroy "our files" and inquiries be sent to Archives at HSO Jax? When I say "our files" I mean Section 1&2 we are maintaining for 10 years when the practitioner has transferred from our facility.

Per CDR (Ret) Georgi Irvine: BUMEDINST 6320.66C, Section 4, para 6 states, "Local Retention of Credentials Information. Upon retirement, privileging authorities shall maintain copies of all PARs with associated privilege sheets and applications for staff appointments or with associated requests and authorizations to exercise privileges, including endorsements, completed by the privileging authority for 10 years. "

Per Ms. Dawn Tindell: Archives suggestion from PAC Conference April 2002: The PAC can look on CCQAS, and use the Provider Locator to see where that practitioner's record is located. The PAC can also look on the Internet for the Navy Locator. http://publicdirectory.smartlink.navy.mil/cgi-bin/web500gw-2.1b3/nph-web500gw

Also, when a PAC sends, and emails, notifying the Archives Department an ICF is being archived, and the PAC sends the PCS in CCQAS, a reply is sent to that email. When Archives receives the record, and if the record was sent certified, the green card is returned, and from the moment the record is received, the Archive Department answers the outside inquiries.

It would be very difficult to let every PAC know each time an archived provider's ICF is received in the Archive Department at the CCPD.

Where in the 6320.66C does it say the provider must have performed "a majority of the Core?"

It doesn't, but it makes logical sense when assessing current competency of a practitioner in the provision of safe, patient, care practices.

This question goes back to a previous question regarding Departmental Specific Criteria, and the setting of thresholds.

It is much easier to set a threshold (patient/procedure volume), of patients to be seen, or specific procedures completed within the past two years, to assess current competency for the individual supplemental privilege.

It is difficult to do this with the Core. The Core represents those privileges, which as a ***group*** constitute the expected baseline scope of practice for a fully trained, and currently competent practitioner of a specific specialty.

The question is: How do we set a threshold for a group of privileges (presuming these are not high-risk, or problem-prone privileges)?

The 6320.66C states, " Because core privileges constitute a representative baseline scope of care, not all privileges in the core are required or expected to be exercised at all times in every facility." Since not all privileges in the Core are required or expected to be exercised, what would equate to a sufficient patient case mix (type of patient/procedures) coupled with appropriate patient volume to equate to current competency? A Majority of the privileges actually practiced.

Therefore, when the Department Head, or Peer Reviewer is assessing current competency, at least a majority of the Core should have been practiced within the past two years, so our Medical/Dental Staff's leaders are assured the practitioner can provide safe, patient, care practices for the Core.

Puerto Rico License: The practitioner got a cashier check for $25.00. It was sent registered mail to PR. 2-months later we still don't have a reply or verification. Can we do a Memorandum for the Record (MFR), and grant privileges?

Yes, but more than a MFR is required. The JCAHO realizes some credentials documents have burned, the organization closed, or are lost. The JCAHO does not have a problem with the granting of privileges in this case, as long as certain procedures are initiated:

- Place a copy of the dated request for renewal, together with a copy of the registration, and place in Section IV in the ICF/IPF.
- If more than one request is made, place copies of all requests, and registration/certification/ FedEx/USPS documentation in the ICF/IPF.
- PHONCONS: If several PHONCONs are made, place a copy of the PHONCON list in the ICF/IPF in Section IV. This can be via Excel Spreadsheet, or MFR.

The Medical Staff will make the decision to approve the appointment with clinical privileges based on the practitioner's history located within the ICF. The decision will be more difficult if this is a new practitioner, with little or no current competency history. In both the above cases, you will have a current NPDB/HIPDB so the Medical Staff will have additional information to use in the decision making process.

NUMI physicians are working at NACC Groton (as long as I've been doing this job) on their operational exemption (waiver). Please verify they need license, or supervision, to work at our facility.

Critical Question, thank you.
Please remember, to provide care within a JCAHO accredited facility, the practitioner MUST

POSSESS either an Active (appropriately waived) license, or a Plan of Supervision.

The Operational Exemption (Waiver) is NOT VALID in an accredited health care facility. The Operational Exemption (Waiver) is ONLY for those practitioners assigned to operational commands. The minute the operational physician comes into an accredited health care facility, the Operational Exemption ceases to be, and the practitioner must be placed under a Plan of Supervision. When the operational practitioner returns to the operational side of the house, the Operational Exemption (Waiver) continues until 12 months from the internship graduation date.

Don't let the JCAHO surveyor catch one of these operational physicians in your accredited command providing care, without a license, or a POS.

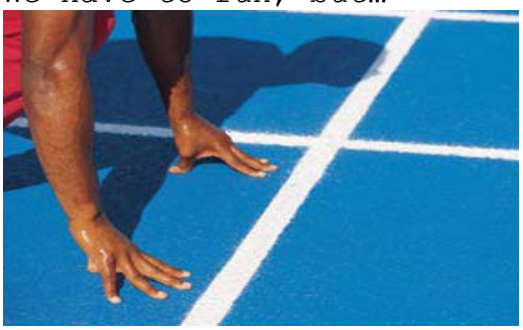
Our ECOMS Committee stated for providers right out of residency, where the residency program verified the member's competency for the privileges they are requesting, that the ECOMS Chair can sign (if he's happy) without the entire committee review (they discuss this at the next meeting). OK?

This can be appropriate in this scenario. A newly graduated intern, or resident does not have a current competency history as an independent practitioner. Therefore, there really is no data to check: licensure status, NPDB/HIPDB, ability to perform, and the current competency documentation.

Therefore, if the provider meets the Navy standard (not just that the ECOMS Chair is happy) at the Department Head (or equivalent) level, at the Directorate (or equivalent) level: the ECOMS Chair can approve, and the file can go forward to the privileging authority. Of course, this practitioner will be discussed at the next ECOMS/ECODS, and approval documented in minutes.

Sandy and I are planning our next PAC Conference. What would you like discussed; what are the relevant topics you need assistance in; who would you like to see as a presenter, and what topic presented?

We have to run, but…



the next DATALINK will be coming out soon.